CONFERENCE COMMITTEE REPORT
DIGEST FOR EHB 1320

Citations Affected: IC 6-1.1-18.5-10; IC 12-15; IC 12-29-1; IC 12-29-2; IC 16-21-6-7; IC 16-39-9-3; IC 12-29-2-6.

Synopsis: Human services. Provides that the maximum appropriation and tax levy for community mental health centers must be annually recalculated based on the increase in the assessed value growth quotient. Authorizes the office of Medicaid policy and planning to implement alternative payment methodologies for payable claim payments to a hospital under certain circumstances. Separates the laws governing the funding of community mental health centers from the laws governing the funding of community mental retardation and other developmental disabilities centers. Repeals a provision that duplicates other provisions added to the same chapter. Allows the state department of health to disclose inpatient and outpatient discharge information to hospitals that have submitted the information. Allows a hospital trade association to disclose health record information received under certain circumstances. Changes a retrieval charge to a labor charge for providing copies of medical records. Eliminates a provision under which a hospital was allowed 180 days to respond to a notice that the hospital was overpaid by the Medicaid program. Makes hospitals subject to the general provision allowing 60 days for a response. Provides alternative options to the nursing facility assessment state plan amendment and waiver request and amends the expiration of the nursing facility quality assessment. Requires the select joint commission on Medicaid oversight to study certain effects resulting from the repeal of continuous eligibility under the Indiana Medicaid program and the children's health insurance program. Requires the state budget committee to review disproportionate share payments for community mental health centers and make recommendations to the general assembly. Makes a technical correction. **(This conference committee report: (1) keeps HB 1320 language concerning tax levies for community mental health centers with changes but removes DSH language; (2) changes nursing facility assessment language to provide alternative modifications to the state Medicaid plan and waiver request and extends assessment; (3) adds SB 161 as the bill left the Senate; (4) adds language from SB 428 concerning the disclosure of certain health record information, implementation of alternative payment methodologies, and changing of retrieval charges to labor charges;**

and (5) adds language requires the state budget committee to remove disproportionate share payments to community mental health centers and make recommendations to the general assembly.)

Effective: Upon passage; July 1, 2003 (retroactive); December 12, 2003 (retroactive); January 1, 2004 (retroactive); July 1, 2004.

Adopted	Rejected

CONFERENCE COMMITTEE REPORT

MR. SPEAKER:

Your Conference Committee appointed to confer with a like committee from the Senate upon Engrossed Senate Amendments to Engrossed House Bill No. 1320 respectfully reports that said two committees have conferred and agreed as follows to wit:

that the House recede from its dissent from all Senate amendments and that the House now concur in all Senate amendments to the bill and that the bill be further amended as follows:

Delete everything after the enacting clause and insert the following:

SECTION 1. IC 6-1.1-18-12, AS ADDED BY P.L.1-2004, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE DECEMBER 12, 2003 (RETROACTIVE)]: Sec. 12. (a) For purposes of this section, "maximum rate" refers to the maximum:

(1) property tax rate or rates; or

(2) special benefits tax rate or rates;

referred to in the statutes listed in subsection (d).

(b) The maximum rate for taxes first due and payable after 2003 is the maximum rate that would have been determined under subsection (e) for taxes first due and payable in 2003 if subsection (e) had applied for taxes first due and payable in 2003.

(c) The maximum rate must be adjusted:

(1) each time an annual adjustment of the assessed value of real property takes effect under IC 6-1.1-4-4.5; and

(2) each time a general reassessment of real property takes effect under IC 6-1.1-4-4.

(d) The statutes to which subsection (a) refers are:

(1) IC 8-10-5-17;

(2) IC 8-22-3-11;

(3) IC 8-22-3-25;

(4) IC 12-29-1-1;

(5) IC 12-29-1-2;

(6) IC 12-29-1-3;

~~(7) IC 12-29-2-13;~~

~~(8)~~ **(7)** IC 12-29-3-6;

~~(9)~~ **(8)** IC 13-21-3-12;

~~(10)~~ **(9)** IC 13-21-3-15;

~~(11)~~ **(10)** IC 14-27-6-30;

~~(12)~~ **(11)** IC 14-33-7-3;

~~(13)~~ **(12)** IC 14-33-21-5;

~~(14)~~ **(13)** IC 15-1-6-2;

~~(15)~~ **(14)** IC 15-1-8-1;

~~(16)~~ **(15)** IC 15-1-8-2;

~~(17)~~ **(16)** IC 16-20-2-18;

~~(18)~~ **(17)** IC 16-20-4-27;

~~(19)~~ **(18)** IC 16-20-7-2;

~~(20)~~ **(19)** IC 16-23-1-29;

~~(21)~~ **(20)** IC 16-23-3-6;

~~(22)~~ **(21)** IC 16-23-4-2;

~~(23)~~ **(22)** IC 16-23-5-6;

~~(24)~~ **(23)** IC 16-23-7-2;

~~(25)~~ **(24)** IC 16-23-8-2;

~~(26)~~ **(25)** IC 16-23-9-2;

~~(27)~~ **(26)** IC 16-41-15-5;

~~(28)~~ **(27)** IC 16-41-33-4;

~~(29)~~ **(28)** IC 20-5-17.5-2;

~~(30)~~ **(29)** IC 20-5-17.5-3;

~~(31)~~ **(30)** IC 20-5-37-4;

~~(32)~~ **(31)** IC 20-14-7-5.1;

~~(33)~~ **(32)** IC 20-14-7-6;

~~(34)~~ **(33)** IC 20-14-13-12;

~~(35)~~ **(34)** IC 21-1-11-3;

~~(36)~~ **(35)** IC 21-2-17-2;

~~(37)~~ **(36)** IC 23-13-17-1;

~~(38)~~ **(37)** IC 23-14-66-2;

~~(39)~~ **(38)** IC 23-14-67-3;

~~(40)~~ **(39)** IC 36-7-13-4;

~~(41)~~ **(40)** IC 36-7-14-28;

~~(42)~~ **(41)** IC 36-7-15.1-16;

~~(43)~~ **(42)** IC 36-8-19-8.5;

~~(44)~~ **(43)** IC 36-9-6.1-2;

~~(45)~~ **(44)** IC 36-9-17.5-4;

~~(46)~~ **(45)** IC 36-9-27-73;

~~(47)~~ **(46)** IC 36-9-29-31;

~~(48)~~ **(47)** IC 36-9-29.1-15;

~~(49)~~ **(48)** IC 36-10-6-2;

~~(50)~~ **(49)** IC 36-10-7-7;

~~(51)~~ **(50)** IC 36-10-7-8;

~~(52)~~ **(51)** IC 36-10-7.5-19; and

~~(53)~~ **(52)** any statute enacted after December 31, 2003, that:

(A) establishes a maximum rate for any part of the:

(i) property taxes; or

(ii) special benefits taxes;

imposed by a political subdivision; and

(B) does not exempt the maximum rate from the adjustment under this section.

(e) The new maximum rate under a statute listed in subsection (d) is the tax rate determined under STEP SEVEN of the following STEPS:

STEP ONE: Determine the maximum rate for the political subdivision levying a property tax or special benefits tax under the statute for the year preceding the year in which the annual adjustment or general reassessment takes effect.

STEP TWO: Determine the actual percentage increase (rounded to the nearest one-hundredth percent (0.01%)) in the assessed value (before the adjustment, if any, under IC 6-1.1-4-4.5) of the taxable property from the year preceding the year the annual adjustment or general reassessment takes effect to the year that the annual adjustment or general reassessment takes effect.

STEP THREE: Determine the three (3) calendar years that immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first take effect.

STEP FOUR: Compute separately, for each of the calendar years determined in STEP THREE, the actual percentage increase (rounded to the nearest one-hundredth percent (0.01%)) in the assessed value (before the adjustment, if any, under IC 6-1.1-4-4.5) of the taxable property from the preceding year.

STEP FIVE: Divide the sum of the three (3) quotients computed in STEP FOUR by three (3).

STEP SIX: Determine the greater of the following:

(A) Zero (0).

(B) The result of the STEP TWO percentage minus the STEP FIVE percentage.

STEP SEVEN: Determine the quotient of the STEP ONE tax rate divided by the sum of one (1) plus the STEP SIX percentage increase.

(f) The department of local government finance shall compute the maximum rate allowed under subsection (e) and provide the rate to each political subdivision with authority to levy a tax under a statute listed in subsection (d).

SECTION 2. IC 6-1.1-18.5-10 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec.

10. (a) The ad valorem property tax levy limits imposed by section 3 of this chapter do not apply to ad valorem property taxes imposed by a civil taxing unit to be used to fund:

(1) community mental health centers under: ~~IC 12-29-2-1~~

(A) IC 12-29-2-1.2, for only those civil taxing units that authorized financial assistance under IC 12-29-1 before 2002 for a community mental health center as long as the tax levy under this section does not exceed the levy authorized in 2002;

(B) IC 12-29-2-2 through ~~IC 12-29-2-6~~ **IC 12-29-2-5; and**

(C) IC 12-29-2-13; or

(2) community mental retardation and other developmental disabilities centers under IC 12-29-1-1;

to the extent that those property taxes are attributable to any increase in the assessed value of the civil taxing unit's taxable property caused by a general reassessment of real property that took effect after February 28, 1979.

(b) For purposes of computing the ad valorem property tax levy limits imposed on a civil taxing unit by section 3 of this chapter, the civil taxing unit's ad valorem property tax levy for a particular calendar year does not include that part of the levy described in subsection (a).

SECTION 3. IC 12-15-13-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 3. (a) If the office of the secretary believes that an overpayment to a provider has occurred, the office of the secretary may do the following:

(1) Notify the provider in writing that the office of the secretary believes that an overpayment has occurred.

(2) Request in the notice that the provider repay the amount of the alleged overpayment, including interest from the date of overpayment.

(b) ~~Except as provided in subsection (c),~~ A provider who receives a notice and request for repayment under subsection (a) may elect to do one (1) of the following:

(1) Repay the amount of the overpayment not later than sixty (60) days after receiving notice from the office of the secretary, including interest from the date of overpayment.

(2) Request a hearing and repay the amount of the alleged overpayment not later than sixty (60) days after receiving notice from the office of the secretary.

(3) Request a hearing not later than sixty (60) days after receiving notice from the office of the secretary and not repay the alleged overpayment, except as provided in subsection (d).

(c) If:

(1) a provider elects to proceed under subsection (b)(2); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider does not owe the money that the office of the secretary believed the provider owed;

the office of the secretary shall return the amount of the alleged overpayment and interest paid and pay the provider interest on the

money from the date of the provider's repayment.

(d) If:

(1) a provider elects to proceed under subsection (b)(3); and

(2) the office of the secretary determines after the hearing and any subsequent appeal that the provider owes the money;

the provider shall pay the amount of the overpayment, including interest from the date of the overpayment.

~~(c) A hospital licensed under IC 16-21 that receives a notice and request for repayment under subsection (a) has one hundred eighty (180) days to elect one (1) of the actions under subsection (b)(1), (b)(2), or (b)(3).~~

~~(f)~~ **(e)** Interest that is due under this section shall be paid at a rate that is determined by the commissioner of the department of state revenue under IC 6-8.1-10-1(c) as follows:

(1) Interest due from a provider to the state shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

(2) Interest due from the state to a provider shall be paid at the rate set by the commissioner for interest payments from the department of state revenue to a taxpayer.

~~(g)~~ **(f)** Proceedings under this section are subject to IC 4-21.5.

SECTION 4. IC 12-15-15-1.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 1.6. (a) This section applies only if the office determines, based on information received from the federal Centers for Medicare and Medicaid Services, that payments made under section 1.5(b) STEP FIVE (A), (B), or (C) of this chapter will not be approved for federal financial participation.**

(b) If the office determines that payments made under section 1.5(b) STEP FIVE (A) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (A) of this chapter if:

(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (A) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (A) of this chapter for that state fiscal year.

(c) If the office determines that payments made under section 1.5(b) STEP FIVE (B) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (B) of this chapter if:

(1) the payments for a state fiscal year are made only to a

hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (B) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (B) of this chapter for that state fiscal year.

(d) If the office determines that payments made under section 1.5(b) STEP FIVE (C) of this chapter will not be approved for federal financial participation, the office may make alternative payments to payments under section 1.5(b) STEP FIVE (C) of this chapter if:

(1) the payments for a state fiscal year are made only to a hospital that would have been eligible for a payment for that state fiscal year under section 1.5(b) STEP FIVE (C) of this chapter; and

(2) the payments for a state fiscal year to each hospital are an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (C) of this chapter for that state fiscal year.

(e) If the office determines, based on information received from the federal Centers for Medicare and Medicaid Services, that payments made under subsection (b), (c), or (d) will not be approved for federal financial participation, the office shall use the funds that would have served as the nonfederal share of these payments for a state fiscal year to serve as the nonfederal share of a payment program for hospitals to be established by the office. The payment program must distribute payments to hospitals for a state fiscal year based upon a methodology determined by the office to be equitable under the circumstances.

SECTION 5. IC 12-15-15-9, AS AMENDED BY P.L.255-2003, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment

under this section.

(c) ~~For a state fiscal year,~~ **Except as provided in section 9.8 of this chapter and** subject to section 9.6 of this chapter, **for a state fiscal year,** the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) A hospital's payment under subsection (c) is in the form of a Medicaid add-on payment. The amount of a hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is funded from the funds transferred to the Medicaid indigent care

trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

(f) The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

(g) Any county's funds identified in subsection (f) that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

(h) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

(i) For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

(j) The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

SECTION 6. IC 12-15-15-9.5, AS ADDED BY P.L.255-2003, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under this section.

(c) ~~For a state fiscal year,~~ **Except as provided in section 9.8 of this chapter and** subject to section 9.6 of this chapter, **for a state fiscal year,** the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) A hospital's payment under subsection (c) is in the form of a

Medicaid add-on payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is derived from funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and not expended under section 9 of this chapter. To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE:

(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed; and

(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.

The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.

(f) Except as provided in subsection (g), the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

(g) If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

(h) Any funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments are made under this section shall be used as provided in IC 12-15-20-2(8)(D).

(i) For purposes of this section:

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an

individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 7. IC 12-15-15-9.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 9.8. (a) This section applies only if the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that a state Medicaid plan amendment implementing the payment methodology in:**

(1) section 9(c) of this chapter; or

(2) section 9.5(c) of this chapter;

will not be approved by the United States Centers for Medicare and Medicaid Services.

(b) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9(c) of this chapter.

(c) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9.5 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9.5(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9.5(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9.5(c) of this chapter.

SECTION 8. IC 12-15-16-1, AS AMENDED BY P.L.113-2000, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 1. (a) A provider that is an acute care hospital licensed under IC 16-21, a state mental health institution under IC 12-24-1-3, or a private psychiatric institution licensed under IC 12-25 is a disproportionate share provider if the provider meets either of the following conditions:

(1) The provider's Medicaid inpatient utilization rate is at least one (1) standard deviation above the mean Medicaid inpatient utilization rate for providers receiving Medicaid payments in Indiana. However, the Medicaid inpatient utilization rate of providers whose low income utilization rate exceeds twenty-five percent (25%) must be excluded in calculating the statewide mean Medicaid inpatient

utilization rate.

(2) The provider's low income utilization rate exceeds twenty-five percent (25%).

(b) An acute care hospital licensed under 16-21 is a municipal disproportionate share provider if the hospital:

(1) has a Medicaid utilization rate greater than one percent (1%); and

(2) is established and operated under IC 16-22-2 or IC 16-23.

(c) A community mental health center that:

(1) is identified in IC 12-29-2-1;

(2) receives funding under:

(A) IC 12-29-1-7(b) **before January 1, 2004; or**

(B) IC 12-29-2-20(c) after December 31, 2003;

or from other county sources; and

(3) provides inpatient services to Medicaid patients;

is a community mental health center disproportionate share provider if the community mental health center's Medicaid inpatient utilization rate is greater than one percent (1%).

(d) A disproportionate share provider under IC 12-15-17 must have at least two (2) obstetricians who have staff privileges and who have agreed to provide obstetric services under the Medicaid program. For a hospital located in a rural area (as defined in Section 1886 of the Social Security Act), an obstetrician includes a physician with staff privileges at the hospital who has agreed to perform nonemergency obstetric procedures. However, this obstetric service requirement does not apply to a provider whose inpatients are predominantly individuals less than eighteen (18) years of age or that did not offer nonemergency obstetric services as of December 21, 1987.

(e) The determination of a provider's status as a disproportionate share provider under this section shall be based on utilization and revenue data from the most recent year for which an audited cost report from the provider is on file with the office.

SECTION 9. IC 12-15-18-5.1, AS AMENDED BY P.L.66-2002, SECTION 8, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 5.1. (a) For state fiscal years ending on or after June 30, 1998, the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 are authorized to make intergovernmental transfers to the Medicaid indigent care trust fund in amounts to be determined jointly by the office and the trustees, and the office and each municipal health and hospital corporation.

(b) The treasurer of state shall annually transfer from appropriations made for the division of mental health and addiction sufficient money to provide the state's share of payments under IC 12-15-16-6(c)(2).

(c) The office shall coordinate the transfers from the trustees and each municipal health and hospital corporation established under IC 16-22-8-6 so that the aggregate intergovernmental transfers, when combined with federal matching funds:

(1) produce payments to each hospital licensed under IC 16-21 that qualifies as a disproportionate share provider under IC 12-15-16-1(a); and

(2) both individually and in the aggregate do not exceed limits prescribed by the federal Centers for Medicare and Medicaid Services.

The trustees and a municipal health and hospital corporation are not required to make intergovernmental transfers under this section. The trustees and a municipal health and hospital corporation may make additional transfers to the Medicaid indigent care trust fund to the extent necessary to make additional payments from the Medicaid indigent care trust fund apply to a prior federal fiscal year as provided in IC 12-15-19-1(b).

(d) A municipal disproportionate share provider (as defined in IC 12-15-16-1) shall transfer to the Medicaid indigent care trust fund an amount determined jointly by the office and the municipal disproportionate share provider. A municipal disproportionate share provider is not required to make intergovernmental transfers under this section. A municipal disproportionate share provider may make additional transfers to the Medicaid indigent care trust fund to the extent necessary to make additional payments from the Medicaid indigent care trust fund apply to a prior federal fiscal year as provided in IC 12-15-19-1(b).

(e) A county making a payment under:

(1) IC 12-29-1-7(b) **before January 1, 2004; or**

(2) IC 12-29-2-20(c) after December 31, 2003;

or from other county sources to a community mental health center qualifying as a community mental health center disproportionate share provider shall certify that the payment represents expenditures that are eligible for federal financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office shall assist a county in making this certification.

SECTION 10. IC 12-29-1-1 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 1. (a) The county executive of a county may authorize the furnishing of financial assistance to ~~the following:~~

~~(1) A community mental health center that is located or will be located in the county.~~

~~(2)~~ a community mental retardation and other developmental disabilities center that is located or will be located in the county.

(b) Assistance authorized under this section shall be used for the following purposes:

(1) Constructing a center.

(2) Operating a center.

(c) Upon request of the county executive, the county fiscal body may appropriate annually from the county's general fund the money to provide financial assistance for the purposes described in subsection (b). The appropriation may not exceed the amount that could be collected from an annual tax levy of not more than three and thirty-three hundredths cents ($0.0333) on each one hundred dollars ($100) of taxable property within the county.

SECTION 11. IC 12-29-1-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec.

2. (a) If ~~a community mental health center or~~ a community mental retardation and other developmental disabilities center is organized to provide services to at least two (2) counties, the county executive of each county may authorize the furnishing of financial assistance for the purposes described in section 1(b) of this chapter.

(b) Upon the request of the county executive of the county, the county fiscal body of each county may appropriate annually from the county's general fund the money to provide financial assistance for the purposes described in section 1(b) of this chapter. The appropriation of each county may not exceed the amount that could be collected from an annual tax levy of three and thirty-three hundredths cents ($0.0333) on each one hundred dollars ($100) of taxable property within the county.

SECTION 12. IC 12-29-1-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 3. (a) The county executive of each county whose residents may receive services from ~~a community mental health center or~~ a community mental retardation and other developmental disabilities center may authorize the furnishing of a share of financial assistance for the purposes described in section 1(b) of this chapter if the following conditions are met:

(1) The facilities for the center are located in a state adjacent to Indiana.

(2) The center is organized to provide services to Indiana residents.

(b) Upon the request of the county executive of a county, the county fiscal body of the county may appropriate annually from the county's general fund the money to provide financial assistance for the purposes described in section 1(b) of this chapter. The appropriations of the county may not exceed the amount that could be collected from an annual tax levy of three and thirty-three hundredths cents ($0.0333) on each one hundred dollars ($100) of taxable property within the county.

SECTION 13. IC 12-29-1-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 4. (a) Bonds of a county may be issued for the construction and equipment or the improvement of a building to house ~~the following:~~

~~(1) A community mental health center.~~

~~(2)~~ a community mental retardation and other developmental disabilities center.

(b) If services are provided to at least two (2) counties:

(1) bonds of the counties involved may be issued to pay the proportionate cost of the project in the proportion determined and agreed upon by the fiscal bodies of the counties involved; or

(2) bonds of one (1) county may be issued and the remaining counties may annually appropriate to the county issuing the bonds amounts to be applied to the payment of the bonds and interest on the bonds in the proportion agreed upon by the county fiscal bodies of the counties involved.

SECTION 14. IC 12-29-1-7, AS AMENDED BY P.L.215-2001, SECTION 78, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 7. (a) On the first Monday

in October, the county auditor shall certify to:

~~(1) the division of mental health and addiction, for a community mental health center;~~

~~(2)~~ **(1)** the division of disability, aging, and rehabilitative services, for a community mental retardation and other developmental disabilities center; and

~~(3)~~ **(2)** the president of the board of directors of each center;

the amount of money that will be provided to the center under this chapter.

(b) The county payment to the center shall be paid by the county treasurer to the treasurer of each center's board of directors in the following manner:

(1) One-half (1/2) of the county payment to the center shall be made on the second Monday in July.

(2) One-half (1/2) of the county payment to the center shall be made on the second Monday in December.

~~A county making a payment under this subsection or from other county sources to a community mental health center that qualifies as a community mental health center disproportionate share provider under IC 12-15-16-1 shall certify that the payment represents expenditures eligible for financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office shall assist a county in making this certification.~~

(c) Payments by the county fiscal body

~~(1) must be in the amounts:~~

~~(A) determined by IC 12-29-2-1 through IC 12-29-2-6; and~~

~~(B) authorized by section 1 of this chapter; and~~

~~(2)~~ are in place of grants from agencies supported within the county solely by county tax money.

SECTION 15. IC 12-29-2-1.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: **Sec. 1.2. (a) The county executive of a county may authorize the furnishing of financial assistance for the purposes described in subsection (b) to a community mental health center that is located or will be located:**

(1) in the county;

(2) anywhere in Indiana, if the community mental health center is organized to provide services to at least two (2) counties, including the county executive's county; or

(3) in an adjacent state, if the center is organized to provide services to Indiana residents, including residents in the county executive's county.

If a community mental health center is organized to serve more than one (1) county, upon request of the county executive, each county fiscal body may appropriate money annually from the county's general fund to provide financial assistance for the community mental health center.

(b) Assistance authorized under this section shall be used for the following purposes:

(1) Constructing a community mental health center.

(2) Operating a community mental health center.

(c) The appropriation from a county authorized under subsection (a) may not exceed the following:

(1) For 2004, the product of the amount determined under section 2(b)(1) of this chapter multiplied by one and five hundred four thousandths (1.504).

(2) For 2005 and each year thereafter, the product of the amount determined under section 2(b)(2) of this chapter for that year multiplied by one and five hundred four thousandths (1.504).

SECTION 16. IC 12-29-2-2, AS AMENDED BY P.L.1-2004, SECTION 54, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 2. (a) ~~Subject to subsections (b), (c), and (d),~~ A county shall fund the operation of community mental health centers in ~~an~~ **the** amount ~~not less than the amount that would be raised by an annual tax rate of one and thirty-three hundredths cents ($0.0133) on each one hundred dollars ($100) of taxable property within the county,~~ **determined under subsection (b),** unless a lower tax ~~rate~~ **levy amount** will be adequate to fulfill the county's financial obligations under this chapter in any of the following situations:

(1) If the total population of the county is served by one (1) center.

(2) If the total population of the county is served by more than one (1) center.

(3) If the partial population of the county is served by one (1) center.

(4) If the partial population of the county is served by more than one (1) center.

~~(b) This subsection applies only to a property tax that is imposed in a county containing a consolidated city. The tax rate permitted under subsection (a) for taxes first due and payable after 1995 is the tax rate permitted under subsection (a) as adjusted under this subsection. For each year in which an annual adjustment of the assessed value of real property will take effect under IC 6-1.1-4-4.5 or a general reassessment of property will take effect, the department of local government finance shall compute the maximum rate permitted under subsection (a) as follows:~~

~~STEP ONE: Determine the maximum rate for the year preceding the year in which the annual adjustment or general reassessment takes effect.~~

~~STEP TWO: Determine the actual percentage increase (rounded to the nearest one-hundredth percent (0.01%)) in the assessed value (before the adjustment, if any, under IC 6-1.1-4-4.5) of the taxable property from the year preceding the year the annual adjustment or general reassessment takes effect to the year that the annual adjustment or general reassessment is effective.~~

~~STEP THREE: Determine the three (3) calendar years that immediately precede the ensuing calendar year and in which a~~

statewide general reassessment of real property does not first become effective.

STEP FOUR: Compute separately, for each of the calendar years determined in STEP THREE, the actual percentage increase (rounded to the nearest one-hundredth percent (0.01%)) in the assessed value (before the adjustment, if any, under IC 6-1.1-4-4.5) of the taxable property from the preceding year.

STEP FIVE: Divide the sum of the three (3) quotients computed in STEP FOUR by three (3).

STEP SIX: Determine the greater of the following:

(A) Zero (0).

(B) The result of the STEP TWO percentage minus the STEP FIVE percentage.

STEP SEVEN: Determine the quotient of:

(A) the STEP ONE tax rate; divided by

(B) one (1) plus the STEP SIX percentage increase.

This maximum rate is the maximum rate under this section until a new maximum rate is computed under this subsection for the next year in which an annual adjustment under IC 6-1.1-4-4.5 or a general reassessment of property will take effect.

(c) With respect to a county to which subsection (b) does not apply, the maximum tax rate permitted under subsection (a) for taxes first due and payable in calendar year 2004 and calendar year 2005 is the maximum tax rate that would have been determined under subsection (d) for taxes first due and payable in 2003 if subsection (d) had applied to the county for taxes first due and payable in 2003.

(d) This subsection applies only to a county to which subsection (b) does not apply. The tax rate permitted under subsection (a) for taxes first due and payable after calendar year 2005 is the tax rate permitted under subsection (c) as adjusted under this subsection. For each year in which an annual adjustment of the assessed value of real property will take effect under IC 6-1.1-4-4.5 or a general reassessment of property will take effect, the department of local government finance shall compute the maximum rate permitted under subsection (a) as follows:

STEP ONE: Determine the maximum rate for the year preceding the year in which the annual adjustment or general reassessment takes effect.

STEP TWO: Determine the actual percentage increase (rounded to the nearest one-hundredth percent (0.01%)) in the assessed value (before the adjustment, if any, under IC 6-1.1-4-4.5) of the taxable property from the year preceding the year the annual adjustment or general reassessment takes effect to the year that the annual adjustment or general reassessment is effective.

STEP THREE: Determine the three (3) calendar years that immediately precede the ensuing calendar year and in which a statewide general reassessment of real property does not first become effective.

STEP FOUR: Compute separately, for each of the calendar years determined under STEP THREE, the actual percentage increase

~~(rounded to the nearest one-hundredth percent (0.01%))~~ ~~in the assessed value (before the adjustment, if any, under IC 6-1.1-4-4.5)~~ ~~of the taxable property from the preceding year.~~

~~STEP FIVE: Divide the sum of the three (3) quotients computed under STEP FOUR by three (3).~~

~~STEP SIX: Determine the greater of the following:~~

~~(A) Zero (0).~~

~~(B) The result of the STEP TWO percentage minus the STEP FIVE percentage.~~

~~STEP SEVEN: Determine the quotient of:~~

~~(A) the STEP ONE tax rate; divided by~~

~~(B) one (1) plus the STEP SIX percentage increase.~~

~~This maximum rate is the maximum rate under this section until a new maximum rate is computed under this subsection for the next year in which an annual adjustment under IC 6-1.1-4-4.5 or a general reassessment of property will take effect.~~

(b) The amount of funding under subsection (a) for taxes first due and payable in a calendar year is the following:

(1) For 2004, the amount is the amount determined under STEP THREE of the following formula:

STEP ONE: Determine the amount that was levied within the county to comply with this section from property taxes first due and payable in 2002.

STEP TWO: Multiply the STEP ONE result by the county's assessed value growth quotient for the ensuing year 2003, as determined under IC 6-1.1-18.5-2.

STEP THREE: Multiply the STEP TWO result by the county's assessed value growth quotient for the ensuing year 2004, as determined under IC 6-1.1-18.5-2.

(2) For 2005 and each year thereafter, the result equal to:

(A) the amount that was levied in the county to comply with this section from property taxes first due and payable in the calendar year immediately preceding the ensuing calendar year; multiplied by

(B) the county's assessed value growth quotient for the ensuing calendar year, as determined under IC 6-1.1-18.5-2.

SECTION 17. IC 12-29-2-13, AS AMENDED BY P.L.215-2001, SECTION 80, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 13. (a) This section applies to ~~a~~ **Lake** County. ~~having a population of not less than four hundred thousand (400,000) but not more than seven hundred thousand (700,000).~~

(b) In addition to any other appropriation under this article, ~~a~~ **the** county annually may fund each center serving the county from the county's general fund in an amount not exceeding ~~the amount that would be raised by a tax rate of one cent ($0.01) on each one hundred dollars ($100) of taxable property within the county.~~ **the following:**

(1) For 2004, the product of the amount determined under

section 2(b)(1) of this chapter multiplied by seven hundred fifty-two thousandths (0.752).

(2) For 2005 and each year thereafter, the product of the amount determined under section 2(b)(2) of this chapter for that year multiplied by seven hundred fifty-two thousandths (0.752).

(c) The receipts from the tax levied under this section shall be used for the leasing, purchasing, constructing, or operating of community residential facilities for the chronically mentally ill (as defined in IC 12-7-2-167).

(d) Money appropriated under this section must be:

(1) budgeted under IC 6-1.1-17; and

(2) included in the center's budget submitted to the division of mental health and addiction.

(e) Permission for a levy increase in excess of the levy limitations may be ordered under IC 6-1.1-18.5-15 only if the levy increase is approved by the division of mental health and addiction for a community mental health center.

SECTION 18. IC 12-29-2-17 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: **Sec. 17. (a) Bonds of a county may be issued for the construction and equipment or the improvement of a building to house a community mental health center.**

(b) If services are provided to at least two (2) counties:

(1) bonds of the counties involved may be issued to pay the proportionate cost of the project in the proportion determined and agreed upon by the fiscal bodies of the counties involved; or

(2) bonds of one (1) county may be issued and the remaining counties may annually appropriate to the county issuing the bonds amounts to be applied to the payment of the bonds and interest on the bonds in the proportion agreed upon by the county fiscal bodies of the counties involved.

SECTION 19. IC 12-29-2-18 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: **Sec. 18. All general Indiana statutes relating to the following apply to the issuance of county bonds under this chapter:**

(1) The filing of a petition requesting the issuance of bonds.

(2) The giving of notice of the following:

(A) The filing of the petition requesting the issuance of the bonds.

(B) The determination to issue bonds.

(C) A hearing on the appropriation of the proceeds of the bonds.

(3) The right of taxpayers to appear and be heard on the proposed appropriation.

(4) The approval of the appropriation by the department of local government finance.

(5) The right of taxpayers to remonstrate against the issuance of bonds.

SECTION 20. IC 12-29-2-19 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: **Sec. 19. If bonds are issued under this chapter:**

(1) the building that is constructed, equipped, or improved with proceeds of the bonds is:

(A) the property of the county issuing the bonds; or

(B) the joint property of the counties involved if the bonds are issued by at least two (2) counties; and

(2) the tax limitations in this chapter do not apply to the levy of taxes to pay the bonds and the interest on the bonds.

SECTION 21. IC 12-29-2-20 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: **Sec. 20. (a) On the first Monday in October, the county auditor shall certify to:**

(1) the division of mental health and addiction, for a community mental health center; and

(2) the president of the board of directors of each community mental health center;

the amount of money that will be provided to the community mental health center under this chapter.

(b) The county payment to the community mental health center shall be paid by the county treasurer to the treasurer of each community mental health center's board of directors in the following manner:

(1) One-half (1/2) of the county payment to the community mental health center shall be made on the second Monday in July.

(2) One-half (1/2) of the county payment to the community mental health center shall be made on the second Monday in December.

(c) A county making a payment under this section or from other county sources to a community mental health center that qualifies as a community mental health center disproportionate share provider under IC 12-15-16-1 shall certify that the payment represents expenditures eligible for financial participation under 42 U.S.C. 1396b(w)(6)(A) and 42 CFR 433.51. The office shall assist a county in making this certification.

(d) Payments by the county fiscal body:

(1) must be in the amounts:

(A) determined by sections 2 through 5 of this chapter; and

(B) authorized by sections 1.2 and 13 of this chapter; and

(2) are in place of grants from agencies supported within the

county solely by county tax money.

SECTION 22. IC 16-21-6-7, AS AMENDED BY P.L.44-2002, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 7. (a) The reports filed under section 3 of this chapter:

(1) may not contain information that personally identifies a patient or a consumer of health services; and

(2) must be open to public inspection.

(b) The state department shall provide copies of the reports filed under section 3 of this chapter to the public upon request, at the state department's actual cost.

(c) The following apply to information that is filed under section 6 of this chapter:

(1) Information filed with the state department's designated contractor:

(A) is confidential; and

(B) must be transferred by the contractor to the state department in a format determined by the state department.

(2) Information filed with the state department or transferred to the state department by the state department's designated contractor is not confidential, except that information that:

(A) personally identifies; or

(B) may be used to personally identify;

a patient or consumer may not be disclosed **to a third party other than to a hospital that has filed inpatient and outpatient discharge information.**

(d) An analysis completed by the state department of information that is filed under section 6 of this chapter:

(1) may not contain information that personally identifies or may be used to personally identify a patient or consumer of health services, unless the information is determined by the state department to be necessary for a public health activity;

(2) must be open to public inspection; and

(3) must be provided to the public by the state department upon request at the state department's actual cost.

SECTION 23. IC 16-39-5-3, AS AMENDED BY P.L.44-2002, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 3. (a) As used in this section,"association" refers to an Indiana hospital trade association founded in 1921.

(b) As used in this section, "data aggregation" means a combination of information obtained from the health records of a provider with information obtained from the health records of one (1) or more other providers to permit data analysis that relates to the health care operations of the providers.

(c) Except as provided in IC 16-39-4-5, the original health record of the patient is the property of the provider and as such may be used by the provider without specific written authorization for legitimate business purposes, including the following:

(1) Submission of claims for payment from third parties.

(2) Collection of accounts.

(3) Litigation defense.

(4) Quality assurance.

(5) Peer review.

(6) Scientific, statistical, and educational purposes.

(d) In use under subsection (c), the provider shall at all times protect the confidentiality of the health record and may disclose the identity of the patient only when disclosure is essential to the provider's business use or to quality assurance and peer review.

(e) A provider may disclose a health record to another provider or to a nonprofit medical research organization to be used in connection with a joint scientific, statistical, or educational project. Each party that receives information from a health record in connection with the joint project shall protect the confidentiality of the health record and may not disclose the patient's identity except as allowed under this article.

(f) A provider may disclose a health record or information obtained from a health record to the association for use in connection with a ~~voluntary~~ data aggregation project undertaken by the association. However, the provider may disclose the identity of a patient to the association only when the disclosure is essential to the project. The association may disclose the information it receives from a provider under this subsection to the state department to be used in connection with a ~~voluntary~~ public health activity **or data aggregation of inpatient and outpatient discharge information submitted under IC 16-21-6-6.** The information disclosed by:

(1) a provider to the association; or

(2) the association to the state department;

under this subsection is confidential.

(g) Information contained in final results obtained by the state department for a ~~voluntary~~ public health activity that:

(1) is based on information disclosed under subsection (f); and

(2) identifies or could be used to determine the identity of a patient;

is confidential. All other information contained in the final results is not confidential.

(h) Information that is:

(1) advisory or deliberative material of a speculative nature; or

(2) an expression of opinion;

including preliminary reports produced in connection with a ~~voluntary~~ public health activity using information disclosed under subsection (f), is confidential and may only be disclosed by the state department to the association and to the provider who disclosed the information to the association.

(i) The association shall, upon the request of a provider that contracts with the association to perform data aggregation, make available information contained in the final results of data aggregation activities performed by the association **in compliance with subsection (f).**

(j) A person who recklessly violates or fails to comply with subsections (e) through (h) commits a Class C infraction. Each day a violation continues constitutes a separate offense.

(k) This chapter does not do any of the following:

(1) Repeal, modify, or amend any statute requiring or authorizing the disclosure of information about any person.

(2) Prevent disclosure or confirmation of information about patients involved in incidents that are reported or required to be reported to governmental agencies and not required to be kept confidential by the governmental agencies.

SECTION 24. IC 16-39-9-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 3. (a) A provider may collect a charge of twenty-five cents ($0.25) per page for making and providing copies of medical records. If the provider collects a ~~retrieval~~ **labor** charge under subsection (b), the provider may not charge for making and providing copies of the first ten (10) pages of a medical record under this subsection.

(b) A provider may collect a fifteen dollar ($15) ~~retrieval~~ **labor** charge in addition to the per page charge collected under subsection (a).

(c) A provider may collect actual postage costs in addition to the charges collected under subsections (a) and (b).

(d) If the person requesting the copies requests that the copies be provided within two (2) working days, and the provider provides the copies within two (2) working days, the provider may collect a fee of ten dollars ($10) in addition to the charges collected under subsections (a) through (c).

SECTION 25. IC 12-29-2-6 IS REPEALED [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)].

SECTION 26. [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)] **(a) IC 12-29-1 and IC 12-29-2, both as amended by this act, apply to property taxes first due and payable after December 31, 2003.**

(b) If the department of local government finance determines that compliance with this act would cause an unreasonable delay in the certification of budgets, tax rates, and tax levies in a county, the department of local government finance may certify budgets, tax rates, and tax levies for the county under IC 6-1.1-18-12, IC 12-29-1, and IC 12-29-2 as if this act had not been passed. However, if the department of local government finance takes this action, the affected county and the department of local government finance shall provide for an additional shortfall property tax levy and an additional budgeted amount in 2005 to replace the revenue lost in 2004 to community mental health centers as a result of certifying budgets, tax rates, and tax levies for the county under IC 6-1.1-18-12, IC 12-29-1, and IC 12-29-2 as if this act had not been passed.

(c) The amount of the shortfall levy under subsection (b) shall be treated as an addition to the amount allowed in 2005 under IC 12-29-2, as amended by this act. The ad valorem property tax levy limits imposed by IC 12-29-2, as amended by this act, do not apply to ad valorem property taxes imposed under subsection (b). The shortfall levy imposed under this SECTION may not be considered in computing ad valorem property tax levies under

IC 12-29-2, as amended by this act, for property taxes first due and payable after 2005.

SECTION 27. P.L.224-2003, SECTION 70, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: SECTION 70. (a) As used in this SECTION, ~~"high Medicaid utilization nursing facility" means the smallest number of those nursing facilities with the greatest number of Medicaid patient days for which it is necessary to assess a lower quality assessment to satisfy the statistical test set forth in 42 CFR 433.68(e)(2)(ii).~~ **"health facility" refers to a health facility is licensed under IC 16-28 as a comprehensive care facility.**

(b) As used in this SECTION, "nursing facility" means a health facility that is

~~(1) licensed under IC 16-28 as a comprehensive care facility; and~~

~~(2)~~ certified for participation in the federal Medicaid program under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.).

(c) As used in this SECTION, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(d) As used in this SECTION, "total annual revenue" does not include revenue from Medicare services provided under Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(e) Effective August 1, 2003, the office shall collect a quality assessment from each nursing facility that has:

(1) a Medicaid utilization rate of at least twenty-five percent (25%); and

(2) at least seven hundred thousand dollars ($700,000) in annual Medicaid revenue, adjusted annually by the average annual percentage increase in Medicaid rates.

(f) **If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsection (e), the office shall revise the state plan amendment and waiver request submitted under subsection (l) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii). In amending the state plan amendment and waiver request under this subsection, the office shall collect a quality assessment effective August 1, 2003, from each health facility except the following:**

(1) A continuing care retirement community.

(2) A health facility that only receives revenue from Medicare services provided under 42 USC 1395 et seq.

(3) A health facility that has less than seven hundred fifty thousand dollars ($750,000) in total annual revenue, adjusted annually by the average annual percentage increase in Medicaid rates.

(4) The Indiana Veterans' Home.

Any revision to the state plan amendment or waiver request under this subsection is subject to and must comply with the

provisions of this SECTION.

(g) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under this SECTION using the methodology described in subsections (e) and (f), the office shall revise the state plan amendment and waiver request submitted under subsection (l) as soon as possible to demonstrate compliance with 42 CFR 433.68(e)(2)(ii) and to collect a quality assessment from health facilities effective August 1, 2003. In amending the state plan amendment and waiver request under this subsection, the office may modify the parameters described in subsection (f)(1) through (f)(4). However, if the office determines a need to modify the parameters described in subsection (f)(1) through (f)(4), the office shall modify the parameters in order to achieve a methodology and result as similar as possible to the methodology and result described in subsection (f). Any revision of the state plan amendment and waiver request under this subsection is subject to and must comply with the provisions of this SECTION.

(h) The money collected from the quality assessment may be used only to pay the state's share of the costs for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.) as follows:

(1) Twenty percent (20%) as determined by the office.

(2) Eighty percent (80%) to nursing facilities.

~~(g)~~ **(i)** The office may not begin collection of the quality assessment set under this SECTION before the office calculates and begins paying enhanced reimbursement rates set forth in this SECTION.

~~(h)~~ **(j)** If federal financial participation becomes unavailable to match money collected from the quality assessments for the purpose of enhancing reimbursement to nursing facilities for Medicaid services provided under Title XIX of the federal Social Security Act (42 U.S.C. 1396 et seq.), the office shall cease collection of the quality assessment under the SECTION.

~~(i)~~ **(k)** The office shall adopt rules under IC 4-22-2 to implement this act.

~~(j)~~ **(l)** Not later than July 1, 2003, the office shall do the following:

(1) Request the United States Department of Health and Human Services under 42 CFR 433.72 to approve waivers of 42 CFR 433.68(c) and 42 CFR 433.68(d) by demonstrating compliance with 42 CFR 433.68(e)(2)(ii).

(2) Submit any state Medicaid plan amendments to the United States Department of Health and Human Services that are necessary to implement this SECTION.

~~(k)~~ **(m)** After approval of the waivers and state Medicaid plan amendment applied for under subsection ~~(j),~~ **(l),** the office shall implement this SECTION effective July 1, 2003.

~~(l)~~ **(n)** The select joint commission on Medicaid oversight, established by IC 2-5-26-3, shall review the implementation of this SECTION. The

office may not make any change to the reimbursement for nursing facilities unless the select joint commission on Medicaid oversight recommends the reimbursement change.

~~(m)~~ **(o)** A nursing facility may not charge the nursing facility's residents for the amount of the quality assessment that the nursing facility pays under this SECTION.

~~(n)~~ **(p) The office may withdraw a state plan amendment under subsection (e), (f), or (g) only if the office determines that failure to withdraw the state plan amendment will result in the expenditure of state funds not funded by the quality assessment.**

(q) This SECTION expires August 1, ~~2004.~~ **2005.**

SECTION 28. [EFFECTIVE JULY 1, 2004] **(a) In addition to the duties specified under IC 2-5-26, the select joint commission on Medicaid oversight established by IC 2-5-26-3 shall, to the extent the commission determines is feasible after consultation with the office of Medicaid policy and planning established by IC 12-8-6-1, study the following effects of the repeal of continuous eligibility for children under the Indiana Medicaid program and the children's health insurance program established under IC 12-17.6-2:**

(1) Effects on government, including the following:

(A) Costs to Medicaid and the division of family and children established by IC 12-13-1-1 due to more frequent recertification requirements.

(B) Loss of revenue from federal matching funds that could not be obtained because of the repeal of continuous eligibility.

(2) Effects on the economy, including the following:

(A) Indirect cost shifting to providers due to increased charity care because recipients have lapses in eligibility.

(B) Increased burdens on township assistance (poor relief).

(3) Effects on children, including the following:

(A) Increases in the level of uninsured children in Indiana.

(B) Decreases in wellness and the effects on the educational abilities of sicker children.

(4) Effects on families, including the following:

(A) Effects on family income due to the burden of sicker children.

(B) Effects on the ability of parents to maintain stable employment due to sicker children or more burdensome recertification procedures.

(b) The select joint commission on Medicaid oversight shall submit to the legislative council before November 1, 2004, a report of its findings and recommendations concerning the study under subsection (a). The report must be submitted in an electronic format under IC 5-14-6.

(c) This SECTION expires January 1, 2005.

SECTION 29. [EFFECTIVE UPON PASSAGE] **(a) The state budget committee shall review the disproportionate share funding allocations for mental health institutions and community mental health centers for state fiscal year 2004-2005.**

(b) As part of the budget build up process for the 2005 session of the general assembly, the state budget committee shall make recommendations to the general assembly concerning disproportionate share funding for mental health institutions and community mental health centers for the 2005-2007 biennial budget.

(c) This SECTION expires December 31, 2005.

SECTION 30. **An emergency is declared for this act.**

Renumber all SECTIONS consecutively.

(Reference is to EHB 1320 as reprinted February 24, 2004.)

Conference Committee Report

on

Engrossed House Bill 1320

Signed by:

Representative Hasler Chairperson	Senator Miller
Representative Scholer	Senator Simpson
House Conferees	**Senate Conferees**